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DISCUSSION OF METHODS IN PELVIC SURGERY.*

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MR. PRESIDENT: The following brief report of cases I present chiefly for a discussion of operative methods. We all recognize that at present there is no uniform concensus of opinion in either operative methods or technique. A few years ago confidence in some procedures now questioned was absolute, and the results were then thrice better than now.

CASE I. is that of a multinodular fibroid removed from Mrs. P., aged thirty-eight; no children; two doubtful miscarriages. She gave a good history of pelvic inflammatory trouble of long standing. The pain and tenderness had incapacitated her from making a living. Defecation and the passage of flatus was difficult.

Examination showed perfect fixation of the tumor and also anchorage of the pediculated fibroid above.

The removal of this tumor, free and fixed portions, required a careful dissection from the umbilicus to the floor of the pelvis. The omentum was tied off; adhesions of small and large bowel freed; broad adhesions bridging the pelvis and contents of pelvis freed; bladder adhesions to fundus, tubal and ovarian adhesions on both sides freed; tumor delivered and removed. The method adopted here was that of the extraperitoneal treatment of the stump. Recovered.

While the adhesions were extensive and strong, they were strictly healthy. It is always important in such cases to free all visceral adhesions and to leave the viscera in as normal a position as possible before closing the incision. I am satisfied that some deaths and unmanageable distention following similar operations are due to a want of care on the part of the operator in completing his work. This fact I have demonstrated repeatedly in doing over incomplete work of

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others, also in the *nil* mortality of my own hysterectomies. Some years ago I completed a series of forty-three hysterectomies without a death; lost the forty-fourth by an accident. I lost a hysterectomy last August; none since. The present series is now large, and I am convinced the operation is quite as safe and sure as ovariotomy; the patients seem to do even better.

While presenting this specimen, Mr. President, I desire again to call attention to a few points interesting and important in the natural history of these growths.

The specimen presented is typical of the multinodular variety of hard growths. I regret that I have not for contrast one of the smooth myomatous variety. They are not uncommon, but not quite so common as the multinodular; rarely are they found complicated by tubal and ovarian disease; not prone to cystiform or malignant degeneration. Malignancy, if found at all associated with the growth, is commonly found about the cæcum or sigmoid, and seems to be due wholly to pressure. I have found four cases of this nature in my own work; malignancy of the large bowel on the right in two, on the left in two.

I wish again to refer to the causal relation which tubal and ovarian disease bears to the multinodular variety of uterine fibroids. I have repeatedly urged the removal of tubal and ovarian disease in the absence of uterine growths; the patients have delayed or refused, returning to me two or four years later with a uterus studded with fibroids, the tubal and ovarian disease more marked.

This has occurred repeatedly in married and unchaste women under the age of thirty.

The smooth, symmetrical varieties of myoma have occurred in single or clean women free of tubal and ovarian disease.

While a few gynæcologists may deny these statements, my reply will simply be that they have failed to recognize so many things of pathological and surgical importance in their own work and that of others, deny the existence of some troubles, cling to the myths of ancient pathology, and contradict themselves and all they have said every four months, making it scarcely worth while for scientific and earnest, truth-seeking men to pay attention to anything they do or say, except sufficient to prevent it doing mischief.

Here, as in about all multinodular fibroids found in young women, we find tubal and ovarian disease with a history of specific trouble. I unhesitatingly state here that gonorrhœa bears a strong causal relation to early fibroid disease in prostitutes and the colored population of our country. I have a group of six or more white women now suffer-

ing from marked tubal and ovarian disease with multinodular fibroids of the uterus ; they are all young—under age for the development of fibroids ; none of them have ever been pregnant, and they are all the wives of drummers. Again, I have a few that are the wives of doctors—of course professional pride would make me hesitate. We have had some very sweeping statements in regard to prophylaxis in tuberculosis, epilepsy, cholera, etc.—in all contagious and transmissible diseases. I am convinced, from a long and rich experience with the sequelæ of gonorrhœa, that it is of much or more importance to look after this neglected and dangerous disease in clap-stricken men ; they are dangerous objects in a refined community, morally and physically, and are a lasting menace to the health of females.

These observations are wholly clinical in nature.

Case II.—Mrs. M., aged thirty-one years, white, married, one child, three miscarriages, a sufferer for nine years. Many attacks of pelvic inflammatory trouble confining her to bed for periods of months. All this trouble followed the closure of the cervix eight years ago. Not pregnant since closure of the cervix. Some four months ago an absent period was followed by great pain and tenderness, marked anæmia, and emaciation. I found a boggy tumor extending nearly to the umbilicus. Upon section I found omental and bowel adhesions above and the uterus pushed far forward. When I freed the omental and bowel adhesions I evacuated a quart or more of decomposing blood-clot. The irrigation was a very copious one, using five large pitchers of water, following by glass drainage. The clot had become quite offensive.

She has made an easy recovery. Surgery beyond irrigation and drainage would have destroyed her.

Case III.—March 31, 1894. Mrs. S., white, aged twenty-nine. Two children at term, both complicated labors, dead children delivered. Before her first conception she was sent to me for some obscure trouble on the left side. I recognized tubal and ovarian disease on that side and advised local treatment. She conceived and went to term. The labor was complicated by a malpresentation requiring a high application of the forceps, and she was delivered of a stillborn child.

About two years later she again conceived, went to term, and was attended by a midwife. The labor was complicated by a breech presentation and the patient was delivered of a stillborn child. Three days after delivery, and two weeks before the section, she had pelvic pain and chill followed by high temperature.

Her family physician found a swelling on the left side higher than the region of the left ovary; this increased rapidly with greater tenderness and pain, temperature ranging high. Section and removal was decided upon. The position of ovary and tube indicated prolonged and high fixation; the ovary had formed an enormous sac to the left and above the sigmoid, extending up to the kidney, leaving an enormous hole at that location after its enucleation; it probably contained thirty ounces of pus.

The history of this case is a beautiful fortification of the numerous allusions and demonstrations with specimens of dermoids and pus-tubes I have made to the causal relation they bear to post-puerperal trouble. I have seen great numbers of patients ill or dying of so-called puerperal fever. Some of these conditions were due to small suppurating dermoids, others to old, chronic unilateral tubal disease or small cystomata. There is no theory about these statements, but they are simply the result of numerous experiences at the operating table.

On the right side the tube is patent and the ovary free; later, occlusion may occur with retention.

Curetting is commonly practiced in just this class of cases for endometritis; if this disease exists, in all probability conception will not occur.

In dealing with these cases surgically for years, I have made a most careful study of the masses (right and left), of size, position, fixation, and outline; quite a number I have watched for months or years before the patient would submit to the removal. After the removal I have made a careful study as to the possibility of such pus conduits discharging their contents through the uterus. I am now satisfied that it is the least frequent source of spontaneous evacuation—that they will in all cases open through the large or small bowel, bladder, vagina, or other points, before discharging through the hardened, thickened, contracted uterine extremity of the tube. I have repeatedly made the statement that pus-tubes never discharge through the uterine cavity; now I desire to repeat it with unqualified emphasis. This statement has been recently and repeatedly challenged; first, by a class of men who ought to know better; second, by a class that have had neither practical experience nor observation justifying the challenge. They now claim in large numbers that the globular and sausage-shaped masses diminish in size under manipulation and discharge through the uterine cavity. Others that a great many abscesses discharge spontaneously through the uterus, vagina, or rectum, and are thus

completely cured; through the vagina or through the rectum is a common source of slough, but these are delayed, neglected, and unfortunate cases, and are not thus completely cured.

Now I challenge this class of men to demonstrate, before and after operations, to competent spectators the truth of the statement. Some of them tell us, "I have pressed it out in many cases."

The cases are sufficiently numerous to settle this question at any time to the entire satisfaction of all gynæcologists. First, they can squeeze it out by manipulation. They can take a typical case, or fifty of them, compress or manipulate freely the tortuous distended tubes or pus conduits and ovarian abscesses, and not a drop of their contents can at any time be expelled into the uterine cavity. Fingers or the Sims speculum may be placed in the vagina while this is going on, and, if successful, an ocular inspection can be made. Again, I challenge them to make the demonstration after the removal of the pus conduits, provided the tubes have been removed at their very roots. Neither demonstration has as yet been made. They have made all sorts of theoretical claims for the curette, gauze drain, dilatation, irrigation, manipulation, etc, without the least ground in fact to justify their claims for drainage of pus-tubes. Some of these men have never seen a pus-tube; others have never seen an abdominal section of any sort.

Case IV.—Mrs. A., aged thirty-nine, seven children, one miscarriage. For the last year emaciation has been marked. Intraperitoneal nodular growths were recognized six months ago. The growth was rather rapid. Pressure symptoms well marked, with some ascites.

Diagnosis.—Physical signs those of multinodular fibroid. Two large projecting, resisting masses extending well up into the renal regions. Physical appearance was that of a woman suffering from ovarian disease. Our diagnosis was multinodular fibroid.

Section, August 31, 1894.—Double ovariotomy. Drainage.

Pathological Condition.—Large sarcomas of both ovaries, kidney-shaped and size of small adult head. Numerous adhesions—parietal, pelvic, and visceral. General invasion of bowel and mesentery.

Case V.—Miss R. M., aged twenty-four, colored. Admitted September 4, 1894.

Diagnosis.—Double pyosalpinx and probable ovarian abscesses. Subjective symptoms well marked. Severe pelvic pain intensified by locomotion. Painful and difficult defecation and micturition. Febrile disturbance with rapid emaciation. Objective signs. Tortuous and symmetrical, painful fixed masses completely filling the pelvis.

Section, September 5, 1894.—Huge pus-tubes and ovarian abscesses enucleated; there had been a general descent of pelvic viscera. A small portion of ileum strongly adherent to pus-tube on the right low down, the most common point for small bowel adhesion. More than twenty times in the last three months' work I have found the ileum adherent on the right side, varying from one inch to twenty inches. The appendix was also found strongly adherent and disorganized. In a good number of neglected cases—neglect due to the so-called conservative papers and discussions—I have found the head of the cæcum, ileum, and pus-tube and ovarian abscess strongly adherent. On the other side the sigmoid in puriform accumulations strongly adherent.

Surgery for puriform collections at present has become much more complicated than it was a few years ago. Mortality has also increased. The number of incomplete and abandoned operations is swelling. Operators are weakening on the old, tried, and well-tested procedures, trying numerous other methods that have absolutely nothing to recommend them.

The vaginal method for the removal of diseased appendages is a dangerous and incomplete procedure. I can not conceive of an operator with varied experience in the removal of diseased appendages by abdominal section trying a vaginal operation. I am further convinced that those who do the vaginal operation fail to recognize the extent and true nature of complications, do incomplete work with a high mortality, and continue to do incomplete work by the vaginal method. They occasionally remove a little healthy uterus crowded down by puriform disease. The healthy little uterus removed, rotten tubes and ovaries remain. The whole subject, once so simple, the results so perfect, has again become confused and complicated. The Philadelphia Obstetrical Society has probably done more to establish the true pathology, and bring about good surgery, than any other society in existence, excepting only the British Gynæcological. Numerous criticisms have been made of our pointed discussions. The Society could do the world the greatest possible good by devoting the coming ten meetings wholly to the discussion of pelvic inflammatory troubles.